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ABSTRACT

For schools, acquired immune deficiency syndrome (AIDS) initially represented a policy problem requiring legal and public health experts to assess their ability to exclude students or staff infected with the human immuno-deficiency virus. As the crisis over the potential presence of people with AIDS in the schools abated and with the growing recognition that the disease was not confined to particular risk groups, educators turned toward their pedagogical function. To create classrooms in which children can feel safe to explore and learn about AIDS, drugs, poverty, and homelessness, educators must accept that children live in a world where these issues are encountered at an earlier age than most of us would prefer. Providing this type of environment for children requires the support of teachers as curriculum makers capable of responding to their students' immediate concerns regarding AIDS and related topics while cognizant of the broader bodies of knowledge with which they may be connected. This approach will not work through the imposition of lesson plans from above; instead, administrators must allow adequate time for staff development in which teachers can express their fears. Ultimately, the AIDS curriculum will be more about life than death, more about health than illness, and more about the body politic than the body physical. (24 references) (KM)

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Children, Teachers and the AIDS Curriculum

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No one wants to talk with children about AIDS. Few have been trained for the job. Preparing ourselves for this task requires listening to how the disease enters people's lives, recognizing the multiple ways in which it is experienced. This paper is about how AIDS has entered the lives of children and teachers over the last five years. It is also about the implications of this process for researchers, teacher educators and curriculum makers. To clarify, AIDS here is defined not by the presence of the human immuno-deficiency virus (HIV) itself nor as an underlying medical syndrome upon which has been built a superstructure of myths and misrepresentations. Rather, AIDS is understood as a phenomenon that has been socially constructed through the development of a unique set of practices, images and programs. This is not to deny the existence of viruses, opportunistic infections or the all too real suffering they have caused. However, it is to insist that only through specific, negotiated meanings do we come to know the disease and only through understanding them that we can improve our control over it. Greater familiarity, not heightened fear, is required to prevent the further spread of HIV infection.

I have known about AIDS, then called GRID (Gay Related Immuno-Deficiency), since 1981 when numbers of my friends began to experience strange symptoms and contract bizarre infections that did not fit any recognizable pattern. A small article on the back page of the second section of The New York Times confirmed what a few of us already knew, a new and lethal disease had entered our world. At that time I had just completed my doctoral work and determined to pursue an academic career. So I confined my efforts

to disseminating what little information was available and to raising funds for supportive care not obtainable from mainstream institutions. It was not until 1985 that I began to work fulltime for the fledgling community-based organization that was to become the Long Island Association for AIDS Care.

My assumption was that I would be leaving behind my knowledge of school systems as well as my understandings of parents, children and teachers in order to teach health care professionals about infection control precautions and gay men about safer sex. I could not have anticipated the degree to which my life would continue to be bound up with the lives of families - elderly parents looking after adult children at home, new parents tending to the needs of young children, heterosexual and homosexual couples caring for one another. But AIDS had not only triggered crises for innumerable individual families, indeed in our very concept of the family itself. It had also triggered a crisis in the schools, a crisis that unfolded at the level of policy and at the level of curriculum development and implementation.

This paper is based on my work with teachers, administrators, parents and children in many of the Long Island, NY school districts - poor and middle class, multi-racial and mono-racial, urban and suburban. It reflects the changing terrain of AIDS education, some fundamental inadequacies of our past efforts as well as directions for future work. It also reflects a broader set of concerns about the role of teachers, the purposes of schooling

and the nature of curriculum as it is currently constituted.

Listening to Children

As an early childhood teacher, I had been trained to listen to and observe young children. Raised and educated in a Deweyan tradition, I understood that curriculum was a negotiated process, an outgrowth of the interests of the child and the community. While teachers came to the classroom with an agenda based on knowledge of the community they represented, their art rested in helping children move outward from more narrowly based concerns toward the world of larger ideas. At its best, education enabled children to see the way that the concepts and skills offered by their teachers, and eventually encoded in the formal disciplines, amplified their powers of understanding and control. The role of teachers was to help their students make sense of the world. Imposing predetermined, formal curriculum on children without reference to their lived experience would leave them alienated from the possibilities of school-based learning.

As a doctoral student, enounters with existentialist, Marxist and critical theorists made me more conscious of the sociopolitical political implications of the different approaches to curriculum curriculum making. But it was the phenomenologically oriented educationists who were always mindful of the limitations of scientistically imposed frames of reference and of the need to ground our work in the culture of childhood. They urge us always to return to the children themselves to uncover what it is that seems to matter, how they make sense of

their own experience. To accept such a challenge is to abandon the safety of science that allows us to know children from the privileged position of "objective" adult. It is to risk the uncertainty of an engagement that threatens the boundries between knower and known. (Merleau-Ponty, 1964).

Coming to work in the world of AIDS, I also found no shelter in the positivistic sciences, no distancing mechanisms that would permit an "us" vs. "them" mentality. It was necessary to invent our program at every turn. For while plagues, infectious diseases and critical illnesses have always been a part of human history, none in the contemporary world has brought together quite the same confluence of meanings. Many in community-based organizations became instant experts in retrovirology, health financing and social policy. Technical vocabularies filled with references to reverse transcriptase, DRG's and SSI. Agencies created safer sex education and buddy systems while offering services to whole new categories of people- worried well, HIV positives and PWA's (people with AIDS). Listening to people with the virus was the only way to build an understanding of its impact and to construct services that would respond appropriately. In fact, it was the government's failure to do the same that caused the collapse of its early placebo controlled drug trials and its meager educational efforts to fall on deaf ears (Freedman, 1989).

For schools AIDS initially presented itself as a policy problem requiring legal and public health experts to assess their ability to exclude students or staff with HIV infection (Silin,

1987). This discussion was classically framed in terms of the rights of the individual vs. the good of the community. More productive conversation might have focused on the ethical and practical implications of casting AIDS as a disease of the "other" and the insistance on absolute certainty as the basis of decision making. As the crisis over the potential presence of people with AIDS in the schools abated and with the growing recognition that the disease was not confined to particular risk groups, educators turned toward their pedagogical function. This was a process that was hastened in New York State, and eventually in twenty-seven others, by a department of education mandate for K-12 AIDS education in all schools (Kerr,Allensworth and Gayle, 1989).

When called to assist schools with the process of curriculum formulation, it was natural for me to begin by asking what children were saying about AIDS. This obviously reflected my commitment as a progressive educator as well as my recent experiences learning from people with HIV infection. The responses of teachers clearly indicated that AIDS had entered their classrooms through the voices of their students regardless of formal instruction. Ironically, many of these opportunities occurred in elementary classrooms, classrooms in which the prospect of AIDS education seemed most daunting. Sometimes these voices had been heard at the most unexpected moments, sometimes at more predictable occasions. Almost always, teachers had felt unprepared to take advantage of the moment to begin a dialogue that could have lead to more structured learning.

Interestingly, teachers often had to work hard even to remember these incidents. Emblematic of this forgetfullness were the responses of teachers in a seminar I conducted in a semi-rural community in Eastern Long Island. My inquiry as to what they had observed about their students' knowledge of AIDS was greeted with a painfully long silence. I began to wonder if I had arrived in the only area in New York State that had not been touched by the disease. Then a first grade teracher tentatively raised her hand. She described the pandemonium that had broken out in her classroom that very morning when the principal had announced over the school intercom that AIDS would be the subject of the afternoon staff meeting. Children started accusing each other of having AIDS and warning the teacher not to attend the meeting for fear she might contract it from the guest speaker. A third grade teacher confirmed that AIDS had become the reigning epithet on the playground during recess. It was the label of choice when a group of children wanted to ostracize one whom they deemed socially unacceptable. Games of tag were predicated on avoiding a child who supposedly had AIDS.

To these children the mere mention of AIDS provoked excited responses. Whether motivated by specific fears and anxieties or simply the emotional resonance of the word in our culture, their behaviors accurately mimicked the responses of the majority of adults. To know in more detail what AIDS means to children would require the kind of probing by teachers that leads to a negotiated curriculum. For the moment however, it should be noted that

isolation and fear of contagion are being played out without interruption. Educators must recognize their complicity in discrimination by permitting children to use AIDS as a means to exclude others from the social arena.

But children also reveal their awareness of AIDS in moments that are less incendiary and more focused. In an urban setting, for example, a teacher reported her consternation on a recent class trip upon hearing one child anxiously admonish a friend not to sit down in the subway for fear of contracting AIDS from the seat. The teacher admitted that it was only her concern for the children's safety in the moving train that prompted her to contradict the advice that had been delivered in the most serious tone. A colleague at the same meeting described overhearing one little boy warning another not to pick up a stick in the park. The warning was based on the child's knowledge that drug users frequented the area at night and his belief that they are the source of HIV infection.

These children appear to know relatively little about AIDS, yet it is a spectre that haunts their movement in the world. For them, and for so many adults as well, fear needs to be replaced by understanding, misinformation by facts. AIDS is a part of daily life and should be treated as such in schools. To be meaningful, AIDS information shouldn't be held for the fourth grade science curriculum or sixth grade health class when it may seem irrelevant or too abstract. Not to engage with children, even to counter false information about transmission, is to foster the belief that

AIDS is a mystery, a taboo subject that teachers can not or will not address.

Thinking About Childhood

While for some adults the reluctance to talk with children about AIDS reflects their own lack of knowledge, for others it is part of a consciously articulated belief system about the nature of childhood. In one California town, for example, kindergarten teachers have opposed any discussion of AIDS in their classrooms because they want to protect children from such unpleasant and what they see as irrelevant subjects. In New York, the state AIDS Instructional Guide (1987) barely mentions AIDS in its K-3 lessons.

When Young Children, the journal of the National Association for the Education of Young Children, published its first and only AIDS article entitled "What we should and should not tell our children about AIDS," it emphasized that the role of the teacher was to sooth the potentially frightened child and avoid the presentation of unnecessary information (Skeen and Hudson,1987). A more recent article on substance abuse prevention reinforces a similiar philosophy. Misleadingly titled "Drug Abuse Prevention Begins in Early Childhood (And is much more than a matter of instructing young children about drugs!)", it deals solely with the need for parent education and analysis of parenting styles that promote positive self-images among children (Oyemade and Washington, 1989). In both articles there is little recognition that children may be all too aware of the social

problems that exist in their communities. While teachers are constantly reminded of the need to structure environments that are psychologically supportive of personal growth, never is it suggested that they take the lead in providing information about AIDS or drugs, nor are they encouraged to help students sort through the multiple meanings they may have already assigned to them.

In the 1980's educators looked at the way that the social environment was changing the experience of childhood - from the growth of electronic information sources and parental pressures to the increasing isolation of children in age-segregated institutions (Postman, 1982; Elkind, 1981; Suransky, 1982). While addressing the issue from different theoretical perspectives, these writers all hold in tension what we have learned about the social construction of childhood, the embeddedness of our ideas in specific historical contexts, and what may be optimal conditions for children's growth. Wanting the newcomer to feel at home in the world, we struggle with the degree to which we see childhood as a separate life period requiring specialized protections and professionalized care and the degree to which we see it as a time for full participation in the on-going life of the community.

What teachers think about childhood influences how or even if they will approach AIDS with their students. For some, children inhabit a very different world from adults. Despite what they may be exposed to at home, on the street or in the media, they require educational settings where the flow of information is carefully

controlled. In contrast, others suggest that what happens to children outside of school become the object of classroom study. The school as a safe place to make sense of the complex and confusing realities of daily life. Teachers who believe in this approach are more likely to provide opportunities for critical social issues to become part of the curriculum. For example, I observed a teacher of six and seven year olds open a class meeting with the simple question,"What do people use drugs for"? Information and misinformation poured forth from the children. They debated the ethical implications of the use of steroids by Olympic athletes (a subject very much in the news at the time), tried to understand how people actually snort cocaine (believing that it is placed on the outside of the nose) and struggled with why people do things to themselves that they know are harmful. The children saw drugs, rather than infected blood, as the source of HIV infection and clearly equated AIDS with death. They proved themselves to be curious, knowledgeable and capable of thoughtful reflection. Their mistakes were surprisingly rational, the questions they raised worthy of any adult's attention.

In other classrooms the subject of AIDS may come up in a more oblique manner. A second grade teacher reported, for example, that her AIDS curriculum began with the failure of two baby rabbits to thrive. Sitting near the cage with a small group of concerned children, one girl began to wonder out loud if perhaps they might have AIDS. While the teacher told the children that she did not know very much about AIDS, she did not think it

was a disease of animals. Picking up on their concern, the teacher sought out the health teacher to further inform herself and to talk directly with the children. In the kindergarten classroom down the hall, the children had built a block city with a large hospital at its center. In questioning them one day about the occupant of an ambulance speeding towards its entrance, the teacher was informed that it was a person with AIDS who was very, very sick and going to die. For her, this was a moment to explore what the children really knew about AIDS, part of a larger commitment to understand her students and to bring greater definition to their worlds.

To accept that children live in a world where they come to learn about AIDS, drugs, poverty and homelessness at a far earlier age than most of us would prefer, does not mean we are participating in the denial of childhood. But it does mean that we need to create classrooms in which children can feel safe to explore these issues. Moreover, it means that we must learn more about childhood ways of knowing. New research focusing on the strengths and abilities of children, rather than on their developmental deficiencies, has begun to describe their powers in greater detail. For example, Egan (1988) looks at the positive command of orality, the child's use and understanding of abstract concepts, binary oppositions, story, metaphor and humor. Like Egan, Sutton-Smith (1988) emphasizes the role of metaphor in both adult and childhood thinking. He describes the child's mind as multivocal, naturally given to hearing different inner voices and

considering multiple possibilities, and suggests ways that the shool might be more responsive to these characteristics.

Even while those interested in conserving the past would try to limit the role of tne school, the majority are asking it to address an increasingly broad social agenda. Under pressure to do more and to do it better, in a world tnat offers fewer and fewer support systems for children, there is always the danger of reductionism. Schools reduce complex, social problems into simplified fragments of information, adopt pedagogic strategies that focus on measurable, behavioral outcomes and define the child as a "learner," the sum of his/her cognitive competencies. Many teachers see the curriculum in place as the biggest obstacle to effective education, for they recognize that issues such as AIDS cannot be segmented into discrete, forty minute units.

The Teachers' Perspective

Attending to children suggests the informal ways that AIDS enters the school and the daily openings teachers have for beginning a dialogue that can lead to a more formal learning plan. But teachers need to be supported as curriculum makers who can be responsive to their students' immediate concerns while cognizant of the broader bodies of knowledge with which they may be connected. This approach can not work through the imposition of lesson plans from above. Adequate time for staff development in which teachers can express all their rational and irrational fears must be provided (Basch, 1989). In discussing the introduction of anti-bias curriculum, for example, Derman-Sparks (1989) emphasizes

the need for teachers to learn more about the issues and their own attitudes both through personal exploration and group consciousness raising before attempting to implement new ideas.

Although school people like to view themselves as "objective" professionals acting in the best interests of children, when it comes to AIDS, personal values, prejudices and preconceptions play a critical role in determining what information they do and do not provide. Too, as people begin to hear the facts about HIV transmission, they must be able to explore heretofore unrealized concerns. The middle aged woman whose husband has just been through major surgery needs to calculate the odds that he may have received a unit of infected blood; the young male teacher needs to assess his resistence to carrying a condom on his week-end date; and the mother of a grown daughter who shares an apartment with two gay men needs to come to terms with her anxieties.

In a sense AIDS happens all at once. Coming to learn about AIDS in the context of their professional lives, teachers quickly recognize that this disease has meanings that extend far beyond the clinic office or hospital room, meanings that will seep into conversations with their own children, effect attitudes towards friends and family as well as change life-long behaviors. It has meanings that even challenge their sense of safety in the workplace. This is the all-at-onceness of AIDS, a disease that not only destroys an individual's immune system but also breaks down the artificial barriers that we construct between professional and personal lives.

The press for school reform initiated by the publication of A Nation at Risk has only resulted in increased demands for required courses, quantitative measurement and universal standards. Even as leaders of industry and labor are calling for greater teacher autonomy to increase school effectiveness and experiments in teacher-based school governance proliferate, state mandates for AIDS education allocate few resources for staff development (Kenney, Guardado, and Brown, 1989). If teachers are to engage in the decision making activities that would define them as professionals, then they must be given the opportunity to develop the knowledge base appropriate to such responsibilities (Wirth, 1989).

Unfortunately most teachers learn about AIDS through the demands of the highly rationalized curriculum and without time for reflection. It is not surprising, therefore, that they experience AIDS with anger and frustration. First, because AIDS instruction means that they must find room to squeeze an additional topic into their already overcrowded, overorganized days. AIDS becomes another requirement that impinges on what little discretionary time remains to them. Second, because often they are aware of the discrepancy between the logic of the curriculum and the reality of childrens' experiences.

The New York State AIDS Instructional Guide (1987) is a good example of the technocratic mind set that undermines the role of teachers as decision makers. The guide is an interesting political document with its community review panels to assure decency,

denial of the sexual realities of teen-agers lives and its careful attention to parents' rights to withdraw their children from certain lessons. To educators, however, it may appear as a far more curious pedagogical document for the way that it parcels out information across the grades.

The guide presents a total of 37 lesson plans clustered by grade levels. The K-3 lessons deal with health in general, barely mentioning AIDS at all though teachers are told that some children may fear contracting the disease and that their questions should be addressed "honestly and simply." Somewhat less than half of the 4-6 lessons deal with AIDS. They describe communicable diseases, the immune system, how AIDS is not transmitted and how to prevent AIDS by abstaining from drug use. Only in the 7-8 lessons, a majority of which directly address AIDS, is there discussion of the sexual transmission of AIDS and the possibility of prevention through sexual abstinence. Teachers are instructed to emphasize the thirteen ways that abstinence makes us free.

The social and economic consequences of AIDS are confined to a single lesson in the 9-12 lessons which deals with a debate on mandatory testing. Although certain lessons are geared to elicit sympathy for people with AIDS and thus attempt to curb potential discrimination, never does the curriculum address underlying issues like homophobia or addictophobia that form the basis for much of the AIDS hysteria the curriculum is trying to dispel. This superficial approach to "humanizing" the disease belies the extensive introductory comments about the importance of pluralism

and democratic values.

An underlying assumption of this curriculum seems to be that children's minds are compartmentalized, able to deal with AIDS information in a logical, sequential order that permits them, for example, to discuss how AIDS is not transmitted while holding in abeyance for several lessons and/or years how it is transmitted or how to prevent its spread. There appears to be no need to assess what knowledge children come to school with or the kinds of questions that their personal experiences may have already generated. The child is read as a tabula raza when it comes to AIDS. The New York State planners appear to have been attending more to the logical order in which they wanted to present a specific body of information rather than to the psychological order that may reflect children's questions and interests but that may not be predetermined in such a controlled manner. It seems only fair to ask for the voices of the children in the curriculum. But who is listening? Who has the time?

For teachers the introduction of AIDS into the curriculum has also meant preoccupation with negotiating school bureaucracies and calculating the risks of fomenting change. In most school districts where I have worked, teachers are in agreement about institutionally imposed limitations on what may be said. However, they are often in disagreement as to what their individual responses should be. Three solutions to this dilemma are common. The first accepts the limits, but recognizes that there are ways to work around them. The second, more cynical and despairing,

resists any participation in what are perceived to be duplicitous practices. For teachers advocating the former solution, compromise is essential in order to get critical information to their students, while for teachers adopting the latter, the professionaly demeaning role which requires that they respond to questions as raised by students, but not initiate certain "hot" topics, is unacceptable. Placing teachers in a position where they are reliant on student questions, referring students back to their parents for information or to after class counseling sessions can undermine their authority with students. Unfortunately the legitimate anger expressed over the moral bind in which they are placed is too often projected on to the subject of AIDS itself, rather than directed at creating a changed pedagogical context.

A third solution to institutionally imposed limits is based on the teachers sense of privacy and control when the classroom door is closed. These teachers feel that they are free to say what they want when they are alone with their students. But Grumet (1988), exploring the experiences of women teachers as well as the histories of women writers and artists, suggests the self-defeating nature of this strategy. Describing the importance of private spaces for the development of ideas, she also points to the incipient dangers of isolation and privatization that can result when the doors to these rooms are never opened. The potential for community change can be fostered or thwarted by our willingness to make public that which has been nurtured in private.

> There is a dialectic of withdrawal and extension, isolation and community, assertion and submission to aesthetic practice that requires both the studio where the artist harvests silence and the gallery where she serves the fruit of her inquiry to others. Just as I would send the teacher to a room of her own where she can shed the preconceptions that blind her to the responses ofher students, I would ask her to bring the forms that express her understanding of the child and the world to the children, to her sisters who are her colleagues, and to her sisters who are the mothers of the children. The distrust that divides the woman who care for children grows in the dark like mold. The challenge for women who would be artists in their classrooms is to create the ccommunity that will encourage and receive their expression. (p.94)

Teachers can not construct a successful pedagogical response to AIDS in isolation. Nor can the response be perceived as the province of the health teacher alone if it is accepted that there are economic, political and social as well as biomedical strands to untangling the gordian knot that is AIDS (Johnston, 1986). To understand the disease, students must understand the cultural context in which it is occurring. For it is this context that defines how individuals and society at large respond to people with AIDS and assign resources to prevention, research and care. It is easy to see how AIDS lends itself as a subject for current events and social studies classes. It provides many occasions to exercise critical thinking, learn about the history of health care

and distribution of social justice. But there is also a growing literature, novels, plays, poetry, emerging in response to this disease and affording new access through narrative forms. At the same time more and more artists and musicians are turning their attention to the issue. Our curricula should reflect the richness of these imaginative reconstructions as they offer alternative perspectives and routes to understanding AIDS in our world (Klein, 1989; Preston, 1989).

AIDS as a Question of Authority

Preparing teachers to integrate AIDS into the curriculum is a complex process not just because it raises personal concerns for individuals or because it may force them to address new subjects such as sex and death. It is complex because it provokes inquiry into basic philosophical issues about the nature of pedagogy, the meaning of childhood and the role of the teacher as change agent. An incident in the spring of 1986 crystallized for me the underlying theme of this inquiry and much of the teacher discourse on AIDS. At that time I was asked to talk to a group of angry parents and teachers who were attempting to exclude a five year old girl with AIDS from their school. Five minutes into my remarks about the severity of the AIDS problem in the community area, I was interrupted by an angry, bearded man in his mid-thirties who announced himself to be a teacher, an historian of science, as well as a parent in the school. Citing the newness of the disease and the constant flow of information from the medical world, he began to question the credentials of the panelists, a physician,

public health official, school administrator, parent leader and myself, one by one. At that moment of attack rather than becoming defensive, as many of the others had done, I began to relax. As a former teacher, I recognized a familiar issue emerging, the issue of authority. For this irate father was not only challenging the veracity of the specific information we offered but, more significantly, our fundamental right to influence his life and the life of his children.

Although this scene took place four years ago, in the midst of the worst AIDS hysteria, it exemplifies a critical and on-going theme in this work: the challenge that AIDS poses to traditional concepts of authority. For many, authority implies certainty, the right to guide others based on full knowledge of the outcomes of the recommended actions. But AIDS is not about absolutes. It is defined by a series of changing practices, bodies of knowledge and contexts (Crimp, 1988). AIDS educators and policy makers are skilled at juxtaposing theoretical possibilities against actual probabilities, an unsatisfying dialectic for those feeling personally threatened and seeking safety through guarantees. Yet physicians and other officials who assert certainty lose credibility as well. For in their attempt to reassure, they fail to acknowledge the reality of indeterminacy, an acknowledgement that would allow them to form a sympathetic alliance with an anxious audience. The ethical and practical implications of AIDS test our tolerance for uncertainty as well as our commitment to live the democratic principles that speak to inclusive rather than

exclusive modes of behavior.

While the historian described in this incident was particularly direct in his attempt to discredit our authority, or perhaps more succinctly, even the possibility of authoritative knowledge about AIDS, he was raising the same question that emerged in countless sessions with teachers at that time. Teachers were faced with a dual quandry. For they not only saw themselves as possibly in danger because they were acceding to policies based on calculated risks, but also because they were being asked to initiate AIDS instruction for their students without feeling confident about the information they would be transmitting. Obviously, AIDS also meant talking about sex, drugs and death, often taboo subjects that are not easily managed, controlled or reduced to discrete pieces of information. Without certainty, lacking definitive research or a legitimated history to support current assertions, teachers wondered what stance to adopt with regard to the subject, how not to place their own authority in jeopardy with their students.

Helping teachers come to terms with AIDS in the curriculum is not only a matter of helping them to understand complex medical and sociopolitical realities but also one of re-examining their understanding of pedagogical authority. For at the core of any concept of pedagogical authority is a definition of valued knowledge. It is this definition that determines curricular content and method, shaping the way that the teachers view their students, their needs and the legitimation of their own

qualifications for helping students meet these needs. In the case of AIDS education, it is the teacher's own knowledge of the subject that is most problematic (Silin, 1982).

Although there is a degree of latitude, most public school teachers have been trained and work in institutions that support and foster traditional approaches to authority. That is, approaches that ground teachers' rights to teach in their superior knowledge of the world as well as in the ability to use reason. The educational project itself rests on a belief in science, the public validation of knowledge and classical concepts of truth. This approach, growing out of the Enlightenment tradition stressing the control of self, nature and knowledge supports linear, hierarchical relationships. It leaves little room for uncertainty or for students to define their own needs.

When teachers believe that their authority lies in the control of information, the lack of that mastery can lead to a lethal silence. Teachers now recognize that their failure to respond to such teachable moments reflects a lack of confidence in their own AIDS information. A subtle, but most positive shift in attitudes has occurred when professionals refer to their ignorance rather than to the lack of scientific proof. The reservations are less about the validity of scientific knowledge than about their familiarity with it. Yet there is something fundamentally askew when teachers are unwilling to admit to students that they do not know the answers to their questions and use this as a rationale for pretending that the subject does not exist. While the obvious

remedy to this situation is to provide all teachers with a good basic AIDS education so that they feel competent, a long range solution must also be pursued by encouraging teachers and those who work with them to explore the sources of their authority. For AIDS is not the only problematic issue that teachers face in the classroom where the willingness to model the role of learner takes precedence over the traditonal role of knower.

Collaboration in Health and Education

The high degree of control and standardization in American public schools that undermines teacher initiatives has been amply documented by historians and sociologists of education. Teachers who are themselves disempowered because they are denied the choices that would express their pedagogic expertise, are reluctant to take on subjects like illness and death that leave them in undefined territory where previous understandings of authority may seem less relevant. That is, where student/teacher distinctions based on the ownership of knowledge may break down in favor of the greater commonalities that all members of the community share in the face of existential realities.

The "burn-out" experienced by teachers is not unrelated to what the curriculum has become in so many schools - a "no trespassing" sign rather than an invitation to explore our life worlds. The curriculum remains lifeless as long as it is cut off from the roots and connections that should feed it. This is not to suggest a return to the progressive pragmatism of the 1890's or the 1960's demand for relevance, but rather to recognize that if

teachers can not find themselves or the world that matters to them in the curriculum, it is little wonder that students have such difficulty responding to it. A commitment to the curriculum must entail a commitment to the world that it evokes.

The breakdown of hierarchically structured authority relations that may ensue when certainty becomes doubtful is one that has been actively pursued by people with AIDS and their advocates and one that educators might watch carefully. As individuals confront radical care and treatment decisions, the authority of institutions and private practitioners has come under increasing scrutiny. Often people with AIDS now have more information about new drugs or underground developments than their health care provider while, at other times, the provider may have to acknowledge that little is known about how a drug works or even whether it is effective. A collaborative model of health care in which the patient is a full participant seems only appropriate given these circumstances. Such a collaborative model of health care has implications for all professionals who may have once defined their right to practice by the exclusive control of a particular body of knowledge or skills.

As more and more people with AIDS become actively involved in the decisions that effect their care and treatment, they set an agenda for themselves that does not sound so very different from one that a good teachers may set for their students or indeed that teachers as a group may have for their own development. This is an agenda of increasing independence, autonomy and self

reliance. Ivan Illich (1976), in a book written just prior to the emergence of AIDS, makes an illuminating distinction between medical and health care, associating the former with the highly rationalized scientific management of illness offered by experts in institutional settings and the latter with the socio-political process that enables people to make life affirming choices on a daily basis. To Illich, medical care is only a part of a larger set of contextual issues that facilitate or prevent health. This is not to deny the critical role of technology and professional care but to question how our reliance on them effects our sense of dignity and agency.

It would seem that teachers express a similar set of concerns for their students when they question the ultimate meanings of the technocratic curriculum and for themselves when they assess the administrative structures that inhibit their ability to make decisions regarding how and what they will teach. For it is the belief in expert control that undermines teachers who are asked only to implement curriculum designed by others, children who are forced to learn in classrooms in which they are not active participants, and sick people who are made passive observers of the healing process (Rosenberg, 1987). Collaboration in education as in health care may appear risky because it means that experts relinquish some of their control. But it is also a recognition that not all knowledge is about control. While there needs to be space for mastery, there also needs to be a role for understanding and acceptance, emancipation and liberation.

In the end, the AIDS curriculum will be more about life than about death, more about health than about illness, more about the body politic than the body physical. From AIDS we learn about the limits of science and the importance of human vision, the frailty of the body and strength of the spirit, the need to nurture the imagination even as we direct our attention to rational cognitive structures. Although AIDS may challenge our prior understandings of authority, it also offers us an opportunity to examine new models that more acurately reflect who we understand ourselves to be and what we would like our students to become.

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